Campylobacter

Agency: ____

Investigator: ____ Phone number: ____

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: ____ Date of Birth: __/__/__ Estimated? ☐ Age: ____

First and middle name: ____ Gender: ☐ Female ☐ Male ☐ Other ____

Maiden name: ____ Suffix: ____ Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: __/__/__

Address line: ____ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed

Zip: ____ City: ____ Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian

State: ____ County: ____

Phone: (   )-   - Type: ____ Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Long-term care resident: ☐ Yes ☐ No ☐ Unknown Parent/Guardian name: ____

Facility name: ____ Parent/Guardian phone: (   )-   - Type: ____

EVENT

Diagnosis date: __/__/__ Onset date: __/__/__

Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown

Outbreak related: ☐ Yes ☐ No ☐ Unknown

Outbreak name: ____

Exposure setting: ____

Epi-linked: ☐ Yes ☐ No ☐ Unk To whom: ____

Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown

State: ____ Country: ____

Healthcare provider information

Last name: ____

First name: ____

Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA

Facility name: ____

Address line 1: ____

Address line 2: ____

Zip code: ____ City: ____

State: ____ County: ____

Phone : (   )-   - Type: ____

LABORATORY FINDINGS

Laboratory: ____ Accession #: ____ Collection date: __/__/__

Date received: __/__/__ Specimen source: ____ Test type: ____

Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative

Organism: ***Campylobacter*** Serotype:

Laboratory: ____ Accession #: ____ Collection date: __/__/__

Date received: __/__/__ Specimen source: ____ Test type: ____

Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative

Organism: ***Campylobacter*** Serotype:

Laboratory: ____ Accession #: ____ Collection date: __/__/__

Date received: __/__/__ Specimen source: ____ Test type: ____

Result type: ☐ Preliminary ☐ Final Result date: __/__/__ Result: ☐ Positive ☐ Negative

Organism: ***Campylobacter*** Serotype:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____
Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____
Date worked from: / / Address: _____
Date worked to: / / Zip code: _____
Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____
Date removed: / / Phone: ( )- - Type: _____

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Admission date: / / Discharge date: / /
Isolation type: _____
Isolated at entry: ☐ Yes ☐ No ☐ Unk Length: _____
Days hospitalized: _____
Current isolation type: _____
Currently isolated: ☐ Yes ☐ No ☐ Unk

CLINICAL INFO & DIAGNOSIS

Guillain-Barré Diagnosis ☐ Yes ☐ No ☐ Unk Onset Date / /

Reactive Arthritis Diagnosis ☐ Yes ☐ No ☐ Unk Onset Date / /

Symptoms

Diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Nausea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Vomiting ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Headache ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Muscle weakness ☐ Yes ☐ No ☐ Unk _____ Days/Hours

Visible bloody diarrhea ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Fever ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Highest known fever: _____ ☐ °F ☐ °C
Abdominal cramps ☐ Yes ☐ No ☐ Unk _____ Days/Hours
Chills ☐ Yes ☐ No ☐ Unk _____ Days/Hours

First symptom: Most severe symptom: Date returned to normal activities: / /

OTHER LAB FINDINGS

Clinical specimen from case

Was PFGE performed: ☐ Yes ☐ No ☐ Unk

IA-XbaI Pattern		IA-BlnI Pattern		CDC-XbaI Pattern		CDC-BlnI Pattern	

Environmental specimen testing

Food, Medication, or environmental samples tested? ☐ Yes ☐ No ☐ Unk	Describe samples: (indicate which test positive)		
For what were the samples tested? ☐ Campylobacter ☐ E. coli or EHEC ☐ Salmonella ☐ Shigella ☐ Other testing (specify):			
Positive? ☐ Yes ☐ No ☐ Unk		PFGE performed? ☐ Yes ☐ No ☐ Unk	
IA-XbaI Pattern	IA-BlnI Pattern	CDC-XbaI Pattern	CDC-BlnI Pattern

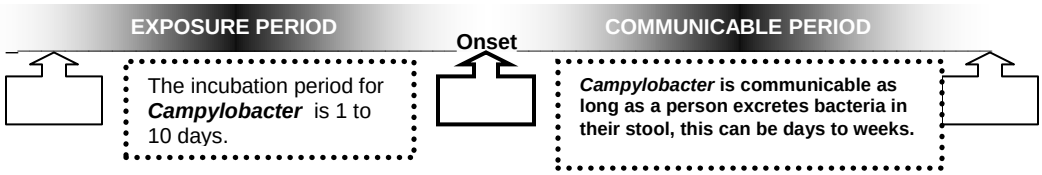
TREATMENT

Antibiotics prescribed? ☐ Yes ☐ No ☐ Unknown

Antibiotic:	Antibiotic:	Antibiotic:
Date started: / /	Date started: / /	Date started: / /
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU	Unit: ☐ mg ☐ ml ☐ IU
# of days:	# of days:	# of days:
# of times a day:	# of times a day:	# of times a day:
Route:	Route:	Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Risk Factors/Travel Information – *In the 10 days prior to onset of symptoms did the case:*

Travel	Travel within Iowa? ☐ Yes ☐ No ☐ Unk	City in Iowa:		Departure date: / /	Return date: / /
	Travel within U.S.? ☐ Yes ☐ No ☐ Unk	State:	City:	Departure date: / /	Return date: / /
	Travel outside U.S.? ☐ Yes ☐ No ☐ Unk	Country:		Departure date: / /	Return date: / /

Visit restaurants? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the table below: *County and address are missing from this table*

Establishment name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Attend Group Gatherings (e.g. weddings, parties)? ☐ Yes ☐ No ☐ Unknown

If Yes, complete the following table:

Location name	Address/Zip	Date visited	Foods consumed	Others ill?
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk
		/ /		☐ Yes ☐ No ☐ Unk

Where did the case purchase groceries in the 2 weeks before the onset of symptoms:

Store name	Address	City/State/Zip	County	Date purchased
				/ /
				/ /
				/ /

Dietary Information – *In the 10 days prior to onset of symptoms did the case consume the following:*

Meat and poultry

Any of these meat products? ☐ Poultry ☐ Ground beef ☐ Meat other than ground meat (salami, jerky, wild game)

Was the meat fully cooked? ☐ Yes ☐ No ☐ Unknown

List all source/types: _____

List all brand names: _____

From dates consumed: / / , / / To dates consumed: / / , / /

Other poultry products

Raw/partially cooked eggs or in foods (e.g. cookie dough)**:** ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Unpasteurized products

Unpasteurized milk: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Unpasteurized juice: ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Other unpasteurized products (e.g. cheese): ☐ Yes ☐ No ☐ Unk From dates consumed: / / To dates consumed: / /

List all source/types: List all brand names:

Animal Exposures – *In the 10 days prior to the onset of symptoms did the case:*

Check all that apply

Visit or live on a farm: ☐ Yes ☐ No ☐ Unknown

Exposed to manure: ☐ Yes ☐ No ☐ Unknown

Have farm animal contact: ☐ Yes ☐ No ☐ Unknown Animals: _____

Have other animal contact in home: ☐ Yes ☐ No ☐ Unknown Animal: Animal sick: ☐ Yes ☐ No ☐ Unk

Visit a petting zoo: ☐ Yes ☐ No ☐ Unknown Touched animals: ☐ Yes ☐ No ☐ Unk Animal: _____

Zoo name: Address/Zip/County:

Water Exposures – *In the 10 days prior to the onset of symptoms did the case:*

Drinking water supply

Home:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**School:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well
Work:	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well	**Child care:**	☐ Bottled ☐ Commercial Delivery	☐ Municipal ☐ Rural water	☐ Well

Other Exposures – *In the 10 days prior to the onset of symptoms did the case:*

Wear diapers ☐ Yes ☐ No ☐ Unk **Have contact with diapers:** ☐ Yes ☐ No ☐ Unk

Have contact with immunocompromised person: ☐ Yes ☐ No ☐ Unk Setting: ☐ Home ☐ Work ☐ Other _____

Have sex with someone with similar symptoms: ☐ Yes ☐ No ☐ Unk Sexual preference: ☐ Hetero ☐ Homo ☐ Bisexual ☐ Unknown

CONTACTS

Number of people living in case's household: _____

Are there close contacts of the case with same symptoms: ☐ Yes ☐ No ☐ Unknown

Close contacts of the case with the same symptoms

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	
			Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Same exposures	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Restaurant ☐ Gatherings ☐ Food ☐ Animal ☐ Water	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	Zip code: Phone: - -

Relationship to case		List symptoms	Symptom onset date	Same exposures	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other		/ /	☐ Restaurant ☐ Gatherings ☐ Food ☐ Animal ☐ Water	☐ Yes ☐ No

If this contact is a case create a new event and/or case for this contact.

NOTES: